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The Challenge to Improve HIV Prevention Programs

By Terry V. Aultman

Since January of 1994, this nation has seen remarkable attention focused on how to prevent the continued transmission of HIV/AIDS. With the initiative of HIV prevention community planning, the Centers for Disease Control and Prevention (CDC) health department grantees are devoting significant energy, time and resources to making decisions about which HIV prevention programs to offer. Communities and scientists are being challenged to devote their time and energy to this decision making process as well and to work with health departments in understanding the epidemic and how to control its spread.

The active and ongoing involvement of over 4,000 persons in prevention community planning is a conservative estimate of the nationwide staffing devoted to this effort. (The CDC estimates at least 180 community planning groups with an average of 22 members.) And this is just counting the formal groups. Not included in this tally are the ad hoc and advisory bodies participating in the process; and the input of what must be hundreds of focus groups, and thousands of key informant interviews. All to build better, more effective prevention programs.

The first year of prevention community planning yielded significant success in building participatory planning processes and establishing year one action plans. Now, health departments and planning groups are in a more challenging phase of implementation: enhancing the direct relationship between the planning process, as documented through the community plan, and the prevention programs operating in the area. The focus of the first year to establish the process for decision making (i.e. community planning) is expanding to include a focus on the impact of decision making on HIV prevention programs.

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Needle Exchange: The Connecticut Example

By Beth Weinstein

In Connecticut, injection drug-use is linked to two-thirds of new AIDS cases. Studies have shown HIV infection rates in injection drug users in Connecticut between 25 and 45 percent. Since 1990, a number of actions have been taken to decrease transmission of HIV in drug users, their partners and their children. These actions have included establishment of needle exchange programs and changes in prescription and paraphernalia laws.

New Haven Needle Exchange Program

In 1990, AIDS activists from the City of New Haven successfully lobbied the Connecticut legislature for approval of a needle exchange program to distribute up to five syringes at a time to injection drug users. The new law also allowed possession of clean and used syringes from the needle exchange program. The program began to operate in November 1990.

The program was well accepted and was supported by the mayor and the police department. Its operations ran smoothly, thus demonstrating that the service could be carried out with no disruption to the community.

Dr. Edward Kaplan of the Yale University School of Organization and Management obtained funding for a unique evaluation of the program. Return needles were tested for the presence of HIV using PCR technology. Using calculations involving the return rate of the needles and the rate of HIV present in the needles, Dr. Kaplan estimated that the program had reduced circulation time of needles in the community and had decreased transmissions of HIV among the program participants by approximately one-third.

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THE CHALLENGE, *continued from page 1*

As with the success of the first year of community planning, meeting the current and future challenges of the program will ultimately be up to the health department and community. There are ways, however, that CDC can help foster community planning processes which provide meaningful and recognizable input to program decisions. First and foremost, CDC can clearly articulate reasonable expectations for impact. Such expectations are set forward in the federal guidance for funding health department HIV prevention programs in fiscal 1996 (Program Announcement 300) which was issued on June 26, 1995. In these funding applications, grantees are asked to summarize the impact of the planning process on their proposed FY 1996 HIV prevention program activities, providing:

•A description of the level of involvement of the community planning group(s) in decisions regarding establishment of proposed program priorities.

•A general description of how the planning process has contributed to an understanding and enhancement of proposed HIV prevention activities to be funded.

•Information regarding the specific impact of the planning process, including proposed shifts in program budget priorities or expenditures; proposed changes in allocation, assignment or function of staff across prevention activities; anticipated changes in the characteristics of clients targeted or served by prevention programs; and modifications (if any) in Requests for Proposals to be issued by the health department.

•A description of any obstacles to the community planning process, specifically in integrating priorities into ongoing program activities and funding decisions.

The FY 1996 continuation funding applications, with the letter(s) of concurrence or non-concurrence from each community planning group in the jurisdiction, were due to CDC by October 2, 1995.

Understanding the impact of HIV prevention community planning on HIV prevention programs is also the major focus of evaluation studies proposed for funding by CDC. External organizations have been asked to develop and implement a research protocol which answers the questions: How is community planning confirming, enhancing, and changing HIV prevention programs? Surveys and case studies have been proposed to begin to answer this question, which above all must recognize that the planning program is in its early years and is most likely just now starting to make a difference to the scope of prevention programs offered in a community.

In addition to working with health departments and community planning groups in establishing reasonable expectations for program impact, CDC is also continuing to provide assistance on implementing effective planning processes. If the community planning process is not sound, and recognized as comprehensive and meaningful, then the impact of the process on prevention programs will be negated. In this second year of community planning, health departments and community planning groups are continuing their work to:

•Broaden the participation of affected communities in the planning process. Groups are recruiting new members, seeking members from under-represented communities, and even increasing the number of planning bodies in the jurisdiction. For example, this spring and summer has seen a number of states move from having one statewide group, to multiple regional groups.

•Enhance the science base of the planning process. Many groups are engaged in important, in-depth investigations regarding the needs of key target populations. More and better information on prevention interventions, and "what works," continues to be sought by community planning groups.

An enhanced system of technical assistance has been arranged by CDC and its national partners to help groups meet the challenges of an evolving community planning process. CDC project officers are working closely with project areas and technical assistance providers to understand these needs and arrange for the best consultative services possible. NAPWA remains an integral part of the national assistance network, with the planned regional meetings affording important opportunities for the exchange of information and ideas. Many groups and individuals are also looking forward to the second edition of Positive Input, NAPWA's highly successful guide to HIV prevention community planning.

The first year of HIV prevention community planning focused on getting the process started. This second year, and the years to come are even more challenging. We must work to build ever more effective planning processes, while never losing sight of the reason for the plans: building better, more effective HIV prevention programs. ■

Terry V. Aultman, M.P.H., joined the U.S. Centers for Disease Control and Prevention in 1991 and worked as a Community Planning Specialist for the last two years, assisting in the implementation of HIV Prevention Community Planning.

Washington Update:

HIV Prevention: 1995

By Mike Shriver

The goal of HIV prevention is to reduce the number of new infections to as close to zero as is humanly possible. Only through real and meaningful partnerships can this goal be achieved. All of the reform to date and all of the challenges that lie ahead of us are based on the belief that informed individuals and communities can be educated to help bring an end to the HIV pandemic. Active participation in community planning processes, as well as active participation in the political processes are two ways in which individuals can become positive forces for change in the world of HIV prevention reform.

Over 19 months ago, HIV prevention reform was put into place. We are just now realizing the initial benefits of these reforms. A number of significant and important events occurred during 1994 in the community planning arena. HIV prevention community planning groups were established in all 50 states, the territories, and the six cities treated like states by the CDC due the high incidence of HIV infection in these cities. The goal of these 65 planning bodies was to submit to the CDC a comprehensive HIV prevention plan that was crafted in partnership by community AIDS service providers, representatives of the affected communities, people living with HIV disease and the state and local health departments. Given the limited time-frame for completion of the first year goal, it is important to note that the 65 HIV prevention community planning groups accomplished this task. Additionally, 1994 saw one of the first significant infusions of critically needed HIV prevention dollars from the 103rd Congress to facilitate better and more effective HIV prevention programs.

1995, however, started off with good news and bad news. First, the good news. Due to the success of the first year of HIV prevention community planning, the 103rd Congress had appropriated increased funding for HIV prevention programs for the second year of the program (47 million new dollars). In fact, Congress specifically appropriated this increase for HIV prevention community planning activities. Yet, within the first month-and-a-half of the new 104th Congress, HIV prevention came under attack from the newly elected Republican majority. The House of Representatives, in their fiscal year 1995 rescissions bill, initially sought to reduce HIV prevention funds by $23 million dollars, reducing by about 50% the increase that the previous congress had adopted. Thanks to the phenomenal work of Congressional Representative Nancy Pelosi (D-CA), as well as the work of community advocates, this money was restored. These increases were awarded to the community planning groups who competitively bid for additional resources to implement the recommendations from their planning documents.

1995 also saw the introduction of legislation that would have created block grants for HIV prevention funding and would have included resources for STDs and TB also. Introduced by Senator Nancy Kassebaum, this bill sought to open a discussion about better management of dwindling resources for disease prevention. Shortly thereafter, the Clinton Administration offered its own version of block grants for HIV prevention, calling its proposal "performance partnership grants." While both the Kassebaum bill and the administration's "performance partnership grants" were based on good intentions, neither fully realized the degree to which HIV prevention has already been reformed, streamlined and made more effective through the implementation of HIV prevention community planning. A tremendous amount of effort has led to the postponement of both proposals.

This is not to say that all is perfect in the realm of HIV prevention reform. As with all new programs, we have seen many issues arise, particularly now that we are well into the second year of the program. For example, the need for well-thought-out and targeted technical assistance support to community planning groups remains to be fully addressed. The need for parity, inclusion and representation are still pressing concerns that need ongoing attention. Individuals from communities that have historically not been part of earlier prevention planning and funding processes --- especially gay men of color, women and adolescents --- need to be brought to the table to be an essential part of prevention planning. These constituencies also deserve adequate technical assistance, where needed, to ensure that they will become equal partners in the process and have a vested stake in the outcome of HIV prevention community planning. This is also true for individuals living with HIV disease, who play a critical role in the prioritization and evaluation of HIV prevention strategies and plans. The National Association of People With AIDS and other organizations currently provide this technical assistance through cooperative agreements with the CDC.

Much attention is now being focused on the need for more and better scientific research to inform HIV prevention program design and evaluation. Behavioral research has a critical role to play in HIV prevention, not only regarding primary HIV prevention efforts (keeping people from

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THE WHITE HOUSE

WASHINGTON

September 18, 1995

Members of The National Association
of People With AIDS
1413 K Street, N.W.
Washington, D.C. 20005-3405

Dear Friends:

Thank you for your letter regarding the Medicaid program. I appreciate knowing your concerns.

I am opposed to efforts by Congress that would radically scale back Medicaid funding or transform it into a block-grant system. Such proposals would damage Medicaid and would hurt states, health care providers, and the many Americans -- including those living with HIV and AIDS -- who rely on this critical program. While Medicaid costs must be contained, we must not risk causing recipients to lose their coverage.

I have proposed a health reform initiative that preserves Medicaid and makes the program more efficient. This proposal will save money and give states the flexibility to pursue other innovative systems of care.

As we work to strengthen Medicaid, I am glad to have the insights of concerned health care providers like you, and I look forward to your continued involvement.

Sincerely,

Bill Clinton

POSITIVE ACTION!

AIDSWATCH FOLLOW-UP

BY LISA RAGAIN

"Think Globally, Act Locally." Odds are that at one time or another, all of us have seen this bumper sticker or heard the phrase, to the point where it has become a cliché. Yet, as with all clichés, there is an important kernel of truth in the heart of the phrase. In this case, the core principle of acting on a local level to affect a broad level of change is more true than ever. The 104th Congress began with the idea that the concerns of local constituents override those of the "special interest" lobbyists in Washington. That means your voice, your actions as advocates and activists are more important than ever.

AIDS funding has already seen victories during this first session. Letters, phone calls and visits from individuals from around the country saved AIDS care and prevention money during the recisions process earlier this year. AIDS activist work also saved the Housing Opportunities for People with AIDS Act for fiscal year '95.

OVER 500 PEOPLE CAME TO WASHINGTON TO LET CONGRESS HEAR THEIR VOICES ON THE RYAN WHITE CARE ACT REAUTHORIZATION, HIV/AIDS FUNDING, AND MEDICAID.

In May, AIDSWatch '95 gave Congress its first big AIDS advocacy event for the year. More than 500 people came to Washington to let Congress hear their voice on issues of Ryan White Care Act reauthorization, HIV/AIDS funding and Medicaid. AIDSWatch '95 served as an introduction to HIV/AIDS issues for many members of Congress. The coming months bring an opportunity to build on the momentum of AIDSWatch, to advocate for AIDS funding for care, prevention, research and housing.

This is a time to act! Members of Congress will be home for Thanksgiving and Christmas recesses from November through the beginning of January. The elections '96 campaigning will also begin at this time. It is the time to start pressing potential candidates for any elected office for their stance on issues critical to people living with HIV disease. Advocates must take this opportunity to organize district visits and community forums and to establish a relationship with their members of Congress. This can be done with individuals, organizations or with other coalitions, such as disability, Medicaid or environmental groups.

The thought of meeting directly with a member of Congress, or with their staff may sound intimidating, but they are your elected representative, and you have a right and a duty as a citizen to ensure that the members know how HIV/AIDS affects you and your community. If you are unable to meet with your member, but have the opportunity to meet with a member of their staff, go ahead with the meeting. Often you can have a greater impact by educating the staff, than the actual member.

Visits have three basic components. The first is to introduce yourself, and tell your story. Explain why funding for HIV/AIDS is important to you, and how it affects your life. If your member has been supportive of AIDS legislation, this is the appropriate time to thank them for their efforts. The second component is to talk about more specific legislation, and then listen to what the member or their staff has to say on the issue. The final step is to make a request for support, or further study, and to follow-up with a letter of thanks for the meeting, or more information if necessary. Use this opportunity to establish a relationship with your member, so when you call or write at a later date, there is recognition of your name and concern.

Other district activities include attending town meetings or forums hosted by your member. Take advantage of question and answer sessions to get your message across. Listen for your member on talk radio or local media and call or write to respond to have your voice heard. Another strategy for district action is to invite your member, preferably now, to visit your coalition, agency or program, so they can picture where federal dollars are being directed in their district.

Your Senator or Member of the House of Representatives may or may not be friendly to HIV/AIDS concerns. You, as a constituent, have the opportunity to impact their work in Washington. To make an appointment, or to find the schedule for your member, call the scheduler in either Washington, or the district office near you. The Congressional switchboard number is 202.225.3121. Local numbers are in the newspaper or phone book. For state specific information on federal AIDS funding in your state, or information on how to do a Congressional visit, call Lisa Ragain at NAPWA, 202.898.0414.

People, like you, have a great opportunity to affect the government policies that directly impact your life. Perhaps the phrase "Think Globally, Act Locally," should be changed for advocates to say "Act Locally, Affect Change Nationally." ■

Lisa Ragain is a Policy Associate in NAPWA's Public Policy Department.

Around The Nation:

HIV Prevention Community Planning groups truly take on the images of their communities. The role of people living with HIV in the work of planning groups vary accordingly. Here is a look at the ways different states handle not only parity, inclusion and representation for people living with HIV disease, but also how these planning groups address prevention for people with HIV disease.

Texas

Texas has 10 regional planning groups, and a state group made up of regional co-chairs. The regional groups meet to form a plan specific to their area, then the state group meets and combines these plans to form a single statewide plan. During the first year of community planning, Texas, like other states, had problems with recruitment, not to mention parity, inclusion and representation. Beginning in January of 1995, the Texas Department of Health (TDH) began a concerted effort to bring all groups up to par on these issues.

This effort resulted in a brochure which explains the community planning process that is used to recruit planning group members and introduce new members to the process. TDH has also formulated a training session for new members, especially co-chairs, with a video for hard to reach areas. Finally, TDH made a model for each region using epidemiological data, to show which populations were at high risk for HIV infection and how many people with AIDS were in each area. Using this profile, TDH and the regions created goals for membership on each planning group. TDH has conducted site visits in some areas and gone directly to groups with a stake in the process to explain community planning and to recruit.

These efforts by TDH have fostered more representative planning groups, with a greater balance of not only at risk populations, but people living with HIV. TDH plans to continue these efforts on parity, inclusion and representation, so membership will better reflect the current and future HIV trends of the HIV epidemic in the state.

The health department co-chair for the El Paso area is Terry Call of the Southwest AIDS Committee. Terry, as a person living with HIV disease, was the community co-chair for the state of Texas during the first, hectic year of community planning and has seen the efforts of TDH in recruitment of people with AIDS in the planning process. Of the twelve members on the planning group, six are HIV positive. Terry feels that the health department has made a good effort to educate the PWA community about community planning, and that these efforts have paid off.

The plan written by the El Paso prevention group will include a proposal for a project to provide case management, harm reduction and psycho-social services for those newly diagnosed with HIV disease. This program would also introduce people with HIV to a program on early intervention services. This project comes out of the planning process, and is in line with the statewide plan. In addition, the state's Request for Funding Proposals (RFPs) are reflective of the community's prevention plan and goals. Texas seems to be heading in the right direction to address parity, inclusion and representation.

New York City

New York City has its own prevention planning group of 55 members. The state of New York and the city share a "PWA" sub-committee that meets regularly to discuss and act on prevention issues specific to people living with HIV disease. The committee reports back on suggestions to their respective groups. The group is currently working on secondary prevention issues for people living with HIV. It has developed a working definition of 12 principles of secondary prevention. The subgroup is currently involved in a literature search to support these principles.

Kim Nickels is a woman living with HIV disease and is the newly elected community co-chair for New York City. She is one of the 25 members of the PWA sub-committee, and is heavily involved in bringing secondary prevention issues to the table. Some 20% of the 55 members on the city planning group are living with HIV disease, and the PWAs are fairly diverse. Kim stated that the work of the PWA sub-committee has given weight and respect to the opinions of the HIV positive members. Acceptance of group members with HIV disease has been fostered because the PWAs are often the most committed and active members.

The New York City planning group has no current training on parity to bring new members up to par, but it is currently beginning to look at the issue.

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Vermont

People living with HIV have been an integral part of Prevention Community Planning in Vermont since the beginning of the process. When community planning began, Vermont's nominations committee consisted entirely of people living with HIV disease. The policy of the planning group is that a minimum 25% of the members are PWAs and the planning group has been able to maintain this level. In addition, 30% of the planning group are people of color, though people of color comprise only about 2% of Vermont's population. In spite of this demographic reality, people of color represent a disproportionate number of HIV/AIDS cases in Vermont.

Another unique aspect of the Vermont planning group is that most of the 30 members don't work in AIDS-related fields. This means that fewer people come into the process with a preconceived idea of what prevention "should" look like. In addition, members don't represent organizations, which means that the tension over competition between agencies is somewhat relieved, and many conflict-of-interest issues are not a significant problem on the state planning group.

All meetings of the planning group have a training component. This brings about a better sense of parity among the members of the group. The flip side of having people not involved with AIDS work is that the vocabulary and terms used in prevention planning are unfamiliar. The training component during each meeting allows people to operate at the same level.

During the first year of planning, Vermont developed seven specific target populations, and one of the populations was people with HIV and their sex partners. The group also definitely identified secondary prevention priorities in their plan. Part of the state's prevention money is set aside to do medical evaluations for people newly diagnosed with HIV disease. In addition, the health department is creating a position to look at early intervention, and the matrix of HIV prevention and services.

People with HIV disease will receive further attention in prevention efforts. People living with HIV and their partners are two of the target populaitons identified during the first year of planning. Vermont has clearly chosen to make people living with HIV a focus of their prevention efforts in the state. ■

For more information call:
Texas: Larry Cuellar, Texas Dep't of Health at 512.458.7208
New York: Kim Nichols, African Services Committee at 212. 683.5019
Vermont: Terje Anderson, Vermont Dep't of Health at 802.863.7572

WASHINGTON UPDATE, ***continued from page 3***

becoming HIV infected) but also in secondary HIV prevention (keeping HIV positive people healthier.) Because of the success of the Office of AIDS Research at the National Institutes of Health (NIH), HIV prevention research needs are now being discussed and planned, with an eye on developing research programs that will inform and improve HIV prevention at the community level.

The struggles to protect and preserve the essential reforms now in place can only get harder in the next few years, given that resources are dwindling and opposition to HIV and AIDS programs continues to thrive. In this regard, the voice of the HIV/AIDS advocacy community must remain active and strong. In the past three years, HIV prevention has finally been recognized and appreciated by the HIV/AIDS advocacy community. Our successes in HIV prevention, while many, must not only be nurtured and supported, they must be protected and augmented. We can afford to do no less. ■

Mike Shriver is the Executive Director of Mobilization Against AIDS, California's oldest nonprofit AIDS advocacy organization.

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PROFILE:

MR. CHRISTENSEN GOES TO WASHINGTON

BY TROY PETENBRINK

As the AIDS epidemic expands and the number of infections rise, rural areas of the United States are slowly responding to the issues of HIV. In Idaho, a state with approximately 300 reported AIDS cases and hundreds more infected with HIV, the Southeast Idaho AIDS Coalition (SEIAC) is doing its part to help one section of rural America.

SEIAC is a community-based organization of people interested in dispelling unfounded fears, breaking down negative stereotypes associated with AIDS and increasing public knowledge and awareness about the transmission and prevention of HIV/AIDS.

In one of SEIAC's brochures there is a statement that reads, "Across [Idaho] our mothers, fathers, sisters, brothers, children and friends are dying because of AIDS — just like thousands of others across the country." One of the people sharing that message is Michael Christensen, a person living with HIV since 1986. Michael has spent the last two years as an HIV/AIDS educator to the people of Pocatello, Idaho and the surrounding area.

AV: You were actually diagnosed with HIV disease while living in Los Angeles. Why did you choose to leave an area with many more services and much more understanding of HIV to return to Idaho?

MC: I felt that life in Idaho was much less stressful and my family wanted me home to be with them while I am ill. I think that is the case for many people living with HIV disease. I have been home since 1993.

AV: AIDS activism is still difficult in large urban areas like New York and San Francisco, where people have been exposed to the epidemic longer and may have a better understanding of HIV/AIDS. I would imagine that HIV/AIDS is not at the top of the list for discussion in Southeast Idaho — is that the case?

MC: That is very true. There is still stigma and stereotypes among the doctors and the general population. But by SEIAC existing and being open about our work, we make the community deal with it. Our churches are making progress — the Church of Latter Day Saints (LDS) is making strides and the First Congregation of the United Church of Christ in Pocatello now has an AIDS ministry. There is always still more work to be done.

AV: What is the biggest obstacle you are facing in terms of being able to do education and advocacy work?

MC: By far the greatest obstacle we face is getting people in the community to accept HIV disease as a problem that affects them. Many in the community still feel that HIV disease is not an issue in Idaho and others still believe HIV disease is a gays-only disease.

AV: How have/are you overcoming these obstacles?

MC: We are trying to get people who do not fit the stereotypes held by those who oppose our work to come out and help educate those individuals. We have had some success in this area but we find it very difficult sometimes to get people like LDS (Ladder Day Saints) members who are positive to be vocal about their status — for obvious reasons. At the same time we are trying to educate and confront the community and the churches about the issue of homophobia. LDS is the dominate religion in this area and influences much of the politics and public policy. However, they understand discrimination first-hand and have been open to listening to why discrimination against gays and lesbians is also wrong. I think we are making progress.

AV: You work with the HIV Prevention Planning Committee. Describe some of the work you are doing in this area.

MC: We are currently working directly with local community members in different areas of the state to discuss issues and concerns on a local level. We are also hoping to see where issues relevant to each individual community can be addressed at state-wide or in a multi-community-wide way.

AV: You attended AIDSWatch '95, in Washington, D.C. How was that experience?

MC: I think we definitely opened a few eyes. One of the most important parts was the fact that we had a diverse group of constituents meeting with the members of Congress and their staffs. It was wonderful to have a heterosexual women living with HIV from Idaho telling her story. I think by actually going to Washington, D.C., we stress the importance of this issue and create an atmosphere of urgency. Our presence also helps to personalize the subject. I strongly encourage people living with HIV disease to visit with their members in Washington, D.C. whenever possible. ■

Troy Petenbrink is NAPWA's Communication's Coordinator.

RESOURCES:

PREVENTION INTERVENTIONS

BY GIDEON FEREBEE

For all of the energy and resources that have been invested into various HIV prevention activities over the last decade or so, there is, unfortunately, only a limited body of rigorous scientific research into how effective prevention interventions have fared. In their new book, **Preventing AIDS: Theories and Methods of Behavioral Interventions,** Ralph J. DiClemente, Ph.D. from the University of Alabama in Birmingham and John L. Peterson, Ph.D. from Georgia State University in Atlanta, have compiled a comprehensive, multi-disciplinary series of articles by behavioral researchers on the types of interventions that have been tried and the conclusions that have been reached in gauging the success of HIV prevention activities for a variety of at-risk and high-risk populations. A wide range of individuals out of university research settings, government experts in infectious disease control and prevention, psychiatrists and psychologists, and others working in the fields of prevention intervention have contributed.

As Jonathan Mann, M.D., Ph.D. states in the forward, "Public health has a legacy of neglect regarding social and behavioral research. The emphasis too often has been on the rapid deployment of reliable diagnostic tools, development of effective vaccines or the design of inexpensive, mass-producible medications to protect society from the ravages of sexually transmitted diseases (STDs). These goals were and are highly laudable, but diverted attention away from the behaviors and possible interventions that might preclude the need for such therapeutic regimens. As importantly, even when medicines have been identified and developed to treat STDs, modifying the various behaviors that lead to the spread of STDs and carefully studying interventions to limit or change the risks that individuals take relative to sexual activity have been largely ignored in the public health arena."

Preventing AIDS: Theories and Methods of Behavioral Interventions, very clearly implies that for all the research into therapeutic drugs, our cultural aversion to delve into the essence of behavioral changes that might lead to more dramatic successes in slowing the spread of the HIV virus has not been a major focus of the public dialogue surrounding the epidemic.

However, there is an expanding body of research into HIV prevention programs directed at adolescents and an emerging body of good studies of local educationally-based prevention interventions that are allowing researchers to assess what is working with young people in modifying risk behaviors. However, as has been found with studies that have followed distinct groups of homosexual men, the conclusions seem to indicate that for young people as well, increased knowledge concerning HIV and AIDS alone neither improves the percentages of individuals avoiding high-risk behavior or guarantees that behavioral change will be sustained.

The book, though technical in its presentation of theoretical models for intervention and theories on how behavioral change is best motivated, is nonetheless interesting reading. It might assist health departments and HIV prevention community planning groups by suggesting strategies that could be adopted and utilized as intervention efforts move into marginalized and under-served communities. Though basic research is still necessary, the book may open up the possibility of linking more community prevention efforts with educational research interests in an effort to methodically study the impact of prevention interventions.

In conclusion the editors write, "The urgency of the HIV epidemic demands that behavior change interventions should be rapidly developed to curb new HIV infections. The most effective research interventions should also be conducted on a scale broad enough to yield direct public health benefits (Kelly et al., 1993). Ultimately, preventing HIV infection will not only depend on the development and evaluation of innovative behavior change approaches, but also on the translation of intervention research into credible community programs." The focus of HIV/AIDS policy will need to incorporate a stronger emphasis on bringing behavioral research and the public health arena into a closer working relationship if HIV prevention programs are to have any chance of succeeding. ■

"Preventing AIDS, Theories and Methods of Behavioral Interventiuons"
DiClemente and Peterson

contact: Ms. Paula Boc
at Plenum Publishing Corporation,
233 Spring Street,
New York, NY 10013-1578
336 pp., $49.50 in US/Canada.

NEEDLE EXCHANGE, *continued from page 1*

These results received widespread attention in Connecticut and throughout the U.S. The study had a significant and positive impact on public opinion regarding access to needles, especially in the state of Connecticut.

Therefore, in early 1992, the Connecticut Department of Health and the state office which regulates pharmacies proposed that the Connecticut legislature change the state laws to allow the sale of syringes without a prescription in pharmacies, and to repeal the paraphernalia laws in order to allow possession of syringes.

In May of 1992, the legislature did pass new laws which allowed, but did not require, pharmacists to sell up to 10 needles and syringes to individuals who do not have medical prescriptions; and allowed anyone to possess up to 10 clean syringes without needing to demonstrate any requirement of a medical need.

From July 1, 1992 through June 30, 1993, the Centers for Disease Control and Prevention (CDC) and the Connecticut Department of Health conducted studies to determine whether the changes in the needle prescription and drug paraphernalia laws were associated with changes in pharmacies' needle and syringe sales practices; needle and syringe sales; injecting drug users' needle and syringe-related purchasing and usage; and the practices and risk of needle-stick injuries reported and/or suffered by police officers. The evaluation findings were as follows:

•Through a surveillance system monitoring needle and syringe sales at selected Connecticut pharmacies, we found that most, but not all, pharmacies sold nonprescription needles and syringes following enactment of the new laws.

•In pharmacies in neighborhoods where there was a high prevalence of injecting drug use, the numbers of nonprescription needles and syringes sold, and needle and syringe transactions increased steadily from July 1992 through June 1993.

•The percentage of injection drug users who were aware of both new laws increased during the first 12 months after the laws' enactment. Nine to 12 months after the new laws were in effect, over two-thirds of the injection drug users interviewed knew about both new laws.

•After the new laws went into effect, injection drug users reported purchasing more needles and syringes at pharmacies and less street purchasing. There was also a shift from purchasing these items on the street to purchasing them at pharmacies. Purchasing needles and syringes at pharmacies was the most frequently reported source for acquiring them>

•The percentage of injection drug users who reported sharing needles and syringes decreased after the passage of the new laws.

•While law enforcement officers in Hartford were less likely to arrest persons for paraphernalia possession after the new laws were enacted, there was no difference in the percentage of injection drug users who reported that they were hassled by police for being in possession of clean needles and syringes.

•Finally, while injection drug users reported changes in needle and syringe possession, Occupational Safety and Health Administration reports of needle-stick injuries among Hartford police decreased after the new laws were in place.

Expansion of Needle Exchange Programs

In 1992, the legislature expanded authorization for more needle exchange programs and provided funding for them as well. New programs were established in Hartford and Bridgeport. An underground program in Willimantic, a small city in Eastern Connecticut, was also legalized.

In addition, the 1994 session of the Connecticut legislature further expanded authority and funding for new needle exchange programs. The cities of Stamford and Danbury established programs which began operation in 1995. Also, the cap on the number of needles which could be exchanged was raised from five to ten. There are now six legal needle exchange programs operating throughout the state of Connecticut.

Needle exchange programs in the state collect information on return rates of syringes, needle sharing and condom use by participants, as well as entry of participants into drug treatment programs. In fact, helping needle exchange clients get into drug treatment is a major goal of the needle exchange programs. Hundreds of participants have, in fact, gained access to drug treatment/rehabilitation through Connecticut's six needle exchange programs. A number of the programs offer on-site counseling and testing to needle exchange clients and a variety of other assistance is offered.

In addition to providing sterile injection equipment to IDUs, needle exchange programs offer a bridge to drug treatment and other health and social services. This role is critical in addressing the many problems experienced by drug users in the state. >

The Role of Pharmacies and Pharmacists

In Connecticut cities without needle exchange programs, pharmacies are the only reliable source of sterile syringes. In cities with needle exchange programs, some injecting drug users obtain syringes both from the needle exchange programs and from pharmacies, while others prefer only one of these two sources. Pharmacies have an advantage over needle exchange programs in that they are generally opened seven day a week and operate throughout the day and into the evening. Also, pharmacy sale of needles requires no public funding. Entering a pharmacy to buy syringes does not mark a person as a drug user. Some drug users fear getting onto needle exchange vans because they don't want to be seen by family members or others. On the other hand, needle exchange programs offer free needles and a variety of services to drug users which pharmacies generally do not offer.

A survey of pharmacists carried out in the spring of 1994 showed that the large majority of pharmacists are selling syringes over the counter without a prescription. Pharmacists responding to the survey expressed support of the law allowing sale of syringes without a prescription. Most of the responding pharmacists recognize the importance of this law in reducing transmission of HIV and other bloodborn pathogens such as hepatitis.

Since 1990, Connecticut has made great strides toward access to sterile syringes by injection drug users. The changes in laws and establishment of needle exchange efforts should reduce transmission of HIV and decrease the number of future cases of AIDS in the state. ■

Beth Weinstein has directed the AIDS Division of the Connecticut Department of Public Health and Addiction Services since November of 1987. The AIDS Division includes AIDS epidemiology, prevention and care programs.

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FEEDBACK:

TEN QUICK QUESTIONS

Please take a moment to talk back to us and help us with our policy work!

	YES	NO
1. Are you a member of your area's Ryan White Planning Council?	_____	_____
2. Are you a member of your area's HIV Prevention Community Planning Group?	_____	_____
3. Does your local AIDS service organization have a prevention program specifically for PWAs?	_____	_____

4. Are you: HIV+ _____
HIV- _____
Status Unknown _____

5. Why did you get tested for HIV?

12

_____

6. When and where were you first told your HIV status?

_____

_____

7. In which national organizations are you active?

_____

_____

8. In which local organizations are you active?

_____

_____

9. Have you ever come to Washington to visit your member of congress?

YES_____ **NO**_____

10. If not, why?_____

_____

_____

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THE ACTIVE VOICE

The Active Voice is a publication of the National Association of People With AIDS (NAPWA). NAPWA is a 501(c)(3) nonprofit organization dedicated to facilitating a richer quality of life for HIV-infected individuals and to preventing the spread of HIV. NAPWA supports all communities affected by the AIDS epidemic with information services and educational resources, national advocacy and technical assistance for community-based organizations. We are committed to ensuring that people with HIV/AIDS have access to high-quality, affordable health and supportive services.

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